



INSTRUCTIONS:

Application to Add or Change COVERING Physician for Certified Registered Nurse Practitioner (CRNP) Or Certified Nurse Midwife (CNM)

This application is not intended for the first-time CRNP or CNM applicant. First-time applicants should use the **APPLICATION FOR APPROVAL TO PRACTICE AS A CERTIFIED REGISTERED NURSE PRACTITIONER OR CERTIFIED NURSE MIDWIFE.**

The applicant who is changing **collaborating** physician should use the application form titled **ADD or CHANGE COLLABORATIVE PRACTICE.**

1. To be considered for approval for advanced practice nursing and collaborative practice in Alabama, the applicant must meet the criteria established in the Alabama Administrative Code Chapter 610-X-5 for CRNP or CNM:
 - (a) Active license as a Registered Nurse in Alabama required for approval and subsequent renewal.
 - (b) Current certification in the clinical specialty requested in this application.
 - (c) Protocol with an Alabama physician
2. Print legibly in black ink or type the required information. Original signatures are required.
3. Complete the "APPLICATION TO ADD OR CHANGE **COVERING** PHYSICIAN FOR CERTIFIED REGISTERED NURSE PRACTITIONER (CRNP) OR CERTIFIED NURSE MIDWIFE (CNM)".

4. Send the application, fee, and documents to:	Express Delivery should be addressed to:
Alabama Board of Nursing P.O. Box 303900 Montgomery, Alabama 36130-3900.	Alabama Board of Nursing 770 Washington Ave, Suite 250 Montgomery, AL 36104-3816.

5. If your address changes after you submit this application, immediately notify the Board office.
6. The approval notice will be mailed to the most recent address on file with the Alabama Board of Nursing for the nurse and for the collaborating physician, respectively.
7. If you change your name, submit a copy of marriage license or court order verifying the name change.
8. For more information, refer to our website at www.abn.alabama.gov or PHONE: 334-242-4060 , or TOLL FREE: 1-800-656-5318



**APPLICATION FOR
ADDING OR CHANGING COVERING PHYSICIAN
FOR
CERTIFIED REGISTERED NURSE PRACTITIONER (CRNP) OR
CERTIFIED NURSE MIDWIFE (CNM)**

Alabama Board of Nursing
P.O. Box 303900
Montgomery, AL 36130-3900

PHONE: 334-242-4060 TOLL FREE: 1-800-656-5318
For more information, refer to our website at www.abn.alabama.gov
COMPLETE THE APPLICATION AS INSTRUCTED, AND MAIL TO THE ABOVE ADDRESS.

SPECIALTY AREA
Check (✓) applicable box for
your specialty area.

☐ CRNP

☐ CNM

**THERE IS NO FEE
FOR THIS SERVICE**

LEGAL NAME _____
Last First Middle Maiden

LIST ANY PREVIOUSLY USED NAMES / ALIASES _____

SOCIAL SECURITY NUMBER _____ ALABAMA RN LICENSE NUMBER _____

PERMANENT STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ COUNTRY _____

DAYTIME PHONE _____ FAX _____ EMAIL _____

COLLABORATING PHYSICIAN:

Name: _____ License Number: _____

Address: _____

City, State, ZIP _____

Provide the **mailing address for the new covering physician(s)** if different from the collaborating physician's address.

TERMINATE THE FOLLOWING COVERING PHYSICIAN(S):

Physician Name	License Number	Effective Date of Termination

As a covering (back-up) physician providing guidance and direction for the applicant:

- I hereby affirm that I am familiar with the current regulations regarding ☐ CRNPs ☐ CNMs, and the collaborative practice protocol filed by the primary collaborating physician.
- I will be accountable for adequately providing oversight of the medical care rendered pursuant to the CRNP/CNM protocol.
- I approved the drug type, dosage, quantity, and number of refills of legend drugs which the CRNP/CNM is authorized to prescribe in the formulary included with the protocol.
- I will assume all responsibility for the medical actions of the CRNP/CNM during the temporary absence of the primary collaborating physician.

ADD THE FOLLOWING COVERING PHYSICIAN(S):

Signature of covering (back-up) physician	Date Signed	Name of the covering physician. (Type or print legibly.)	License Number

I affirm that the information recorded on this application concerning any item contained herein is true and correct. I understand that I may be required to submit documentation to support my affirmation. I further understand that any false statement is in violation of the Code of Alabama and the Board of Nursing Administrative Code and constitutes cause for disciplinary action.

SIGNATURE OF APPLICANT

DATE